Family PACT: Claim Form Completion – HCFA 1500 1

The examples in this section are to help providers bill for Family PACT services on the *HCFA 1500* claim form. While Family PACT claims are generally billed in the same method as Medi-Cal claims, there are some unique differences. Providers should carefully read information in this manual concerning Family PACT "S" diagnosis codes, method of family planning indicators and documentation requirements.

Medi-Cal claim completion instructions are in the *HCFA 1500 Completion* section of the appropriate Part 2 Medi-Cal provider manual. Additional claim preparation information is in the *Forms: Legibility and Completion Standards* section of the appropriate Part 2 manual.

Billing Tips: When completing claims, do not enter the decimal point in Family PACT "S" diagnosis codes, ICD-9-CM codes or dollar amounts. When entering modifiers, do not include hyphens. If requested information does not fit neatly in the *Reserved For Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

In-House Lab, Supplies and Oral Contraceptives

Figure 1: In-house laboratory work. Dispensing of oral contraceptives and supplies.

In this case, a woman has an initial Family PACT visit with education and counseling, including a pregnancy test and a wet mount for vaginitis. She leaves the provider's office using Oral Contraceptives (OC) as her main method of family planning, with condoms as her back-up method. She also leaves with a written prescription for miconazole nitrate to have filled at the pharmacy.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB 0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [X] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]: **92345678Y1**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **JONES MARY**

3. PATIENT'S BIRTH DATE MM DD YY: **01 01 81** SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **1410 BROADWAY**

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: **MAYBERRY** STATE: **CA**

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: **90001** TELEPHONE (Including Area Code): **(916) 555-1222**

Employed [ ] Full-Time Student [ ] Part Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

L5 – NAME OF ORAL CONTRACEPTIVE 3PKS @ $2.00 EA. = $6.00
L6 – 12 CONDOMS @ .08 EAC. + 1 FOAM KIT @ $5.00 = $5.96

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **S101**.
2. **1121**.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 01 01		11		99203			75 00	1 A				
2 03 01 01		11		Z9751			15 00	1 A				
3 03 01 01		11		81025	ZS		15 00	1 A				
4 03 01 01		11		87210	ZS		10 00	1 A				
5 03 01 01		11		X7706			6 00	3 A				
		11		X1500			5 96	1 A				

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

familypact32

2

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	☐ ☐		☐ ☐	$ 126 96	$ 126 96	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED *Fiona Kile* DATE **050201**		**MARY SIMPSOM M.D.** **123 DOCTOR PARK** **MAYBERRY, CA 90001** **(916) 555-6789** PIN# **00C123456** GRP#

PLEASE PRINT OR TYPE

Figure 1. In-house Laboratory Work. Dispensing of Oral Contraceptives and Supplies.

Bilateral Tubal Ligation: Client Referred by Family PACT Provider

Figure 2. Bilateral tubal ligation performed by a non-Family PACT provider. Client referred by a Family PACT provider.

In this case, a non-Family PACT provider performs a tubal ligation upon referral of an enrolled Family PACT provider. This example shows how the surgeon bills for the procedure. (For the corresponding facility claim, see *Figure 2* in the *Family PACT: Claim Form Completion – UB-92* section of this manual.)

The enrolled Family PACT provider has given the surgeon the information necessary to complete the claim, such as the client's identification number, the referring physician's Family PACT identification number, the Family PACT "S" diagnosis, the method indicator and a copy of the sterilization *Consent* (PM 284) form.

PLEASE DO NOT STAPLE IN THIS AREA [redacted]

APPROVED OMB 0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (X) MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]: **91234567Y1**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **MAY SALLY**

3. PATIENT'S BIRTH DATE: **06 06 75** SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **777 CARTER WAY**

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: **OVERTON** STATE: **CA**

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: **90000** TELEPHONE (Including Area Code): **(916) 555-1111**

Employed [ ] Full-Time Student [ ] Part Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **FPO CLINIC**

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **HAP09878F**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: **PM 284 STERILIZATION CONSENT FORM COMPLETED AND SIGNED BY PATIENT ON 090101 AND PLACED IN CLIENT'S FILE.**

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **S702** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 **11 15 01**		**24**		**58670**	**ZK**		**600 00**	**1**	**L**			
2												
3												
4												
5												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ **600 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **600 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Connie Rober* **120201** DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

FAMILY SURGERY CENTER
123 MAIN STREET
ANYTOWN CA 900003
SUR12345F

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MARTIN ESPINOSA M.D.
1000 MAIN STREET
OVERTON, CA 90000
(916) 555-2850

PIN# **00A123456** GRP#

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

Figure 2. Bilateral Tubal Ligation Performed by a Non-Family PACT Provider. Client Referred by Family PACT Provider.

Initial Visit With Lab, Blood Collection and Supplies

Figure 3. Initial visit with in-house laboratory work. Blood specimen is sent to an outside laboratory and supplies are dispensed.

In this case, a new patient visits her doctor, who takes a comprehensive patient history, performs a physical exam and provides education and counseling about all family planing methods. A urine pregnancy test is performed in-house. A dipstick urinalysis is performed in the office for symptoms of Urinary Tract Infection (UTI). Based upon the client history and clinical findings, a blood specimen for glucose was sent to an outside laboratory. The woman is given a prescription for Oral Contraceptives (OC) and an anti-infective. The clinic dispenses condoms and foam.

Enter the appropriate concurrent diagnosis ICD-9-CM in the *Reserved For Local Use* field (Box 19).

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [X] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]: 93456789Y2

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PERKINS CYNTHIA

3. PATIENT'S BIRTH DATE: 01 03 74 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 FARMINGTON

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: SEATOWN STATE: CA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 90002 TELEPHONE (Including Area Code): (916) 555-8301

Employed [ ] Full-Time Student [ ] Part Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

BLOOD SPECIMEN SENT TO UNAFFILIATED LAB.
LINE 5 FOAM KIT @ $8.00 + 12 CONDOMS @ $.33 EA = $11.96 ICD-9 5990

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. S101 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 25 01		11		99204			75 00	1	A			
2 10 25 01		11		Z9751			15 00	1	A			
3 10 25 01		11		81025	ZS		15 00	1	A			
4 10 25 01		11		81000	ZS		5 00	1	A			
5 10 25 01		11		X1500			11 96	1	A			
10 25 01		11		Z5220			4 00	1	A			

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 125 96

29. AMOUNT PAID $

30. BALANCE DUE $ 125 96

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *David Mayp* DATE 111301

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

FELIX BROWN M.D.
123 MAIN AVENUE
ANYTOWN, CA 90013
(916) 555-6789

PIN# **00G123454** GRP#

PLEASE PRINT OR TYPE

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3. Initial Visit. In-house Lab Work. Collection and Handling for Blood Specimen Sent to Outside Laboratory. Dispensing Supplies.

Vasectomy: Non-Family PACT Provider

Figure 4. Vasectomy: Non-Family PACT Provider.

In this case, a man was referred by an enrolled Family PACT provider to a non-Family PACT Medi-Cal provider for a vasectomy. The vasectomy was performed in the doctor's office. In addition to the vasectomy, the surgeon billed for supplies required for the procedure.

The referring Family PACT physician provided the surgeon with the information required to complete the form, such as the client's identification number, the referring provider's Family PACT identification number, the Family PACT "S" diagnosis, the method indicator and a copy of the sterilization *Consent* (PM 284) form.

breast hcfa

10

PLEASE DO NOT STAPLE IN THIS AREA

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APPROVED OMB 0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [X] MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

1a. INSURED'S I.D. NUMBER [FOR PROGRAM IN ITEM 1]: **91234500Y1**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **DOE JOHN**

3. PATIENT'S BIRTH DATE: **11 15 66** SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): **100 21ST STREET**

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: **HOMETOWN** STATE: **CA**

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part Time Student

CITY STATE

ZIP CODE: **90452** TELEPHONE (Including Area Code): **(916) 555-1307**

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH SEX M F

b. OTHER INSURED'S DATE OF BIRTH SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **ABC CLINIC**

17a. I.D. NUMBER OF REFERRING PHYSICIAN: **ZZR21785F**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE: **PM 284 SIGNED ON 020101 AND PLACED IN CLIENT'S FILE.**

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. **S802** 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 16 01		11		Z9780	ZK		500 00	1	L			
2 02 16 01		11		Z9780	ZM		50 00	1	L			
3												
4												
5												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ **550 00**

29. AMOUNT PAID $

30. BALANCE DUE $ **550 00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *John Baker* DATE **031501**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

DR JOHN BAKER M.D.
123 SOUTH 45TH STREET
HOMETOWN, CA 90783
(916) 555-6209

PIN# **00G417360** GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE

Figure 4. Vasectomy. Non-Family PACT Provider Upon Referral of Enrolled Family PACT provider. (**Note:** Fields 17 and 17A).